

WAKE FOREST PEDIATRIC ASSOCIATES, PLLC  
WFPA, PLLC KNIGHTDALE PEDIATRIC OFFICE

CHART: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ SEX: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DOB: \_\_\_\_\_ RACE: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_ LANGUAGE PREFERENCE: \_\_\_\_\_

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EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_

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PERSON RESPONSIBLE FOR PAYMENT: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ SS#: \_\_\_\_\_ DOB: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

E-MAIL: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_

HOME NUMBER: \_\_\_\_\_ CELL NUMBER: \_\_\_\_\_ WORK NUMBER: \_\_\_\_\_

PRIMARY INSURANCE COMPANY: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

INSURANCE POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

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Do you have Medicaid/Carolina Access as secondary insurance coverage?  YES  NO (If so, please provide copy of card)

**We request that charges for office visits be paid at the time of service.** Please make prior arrangements if full payment cannot be made at the time of service. This includes but is not limited to missed appointment fees, missed physical fees, prior balances, copays, etc.

**AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:** I hereby authorize payment directly to the physician for the surgical and/or medical benefits, if any, otherwise payable to me for services as described but not to exceed the reasonable and customary charge for those services.

**AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize the physician to release any information acquired in the course of my examination or treatment to specific insurance carriers, third party payors, or others involved in processing and collection of claims.

**ACKNOWLEDGEMENT OF FINANCIAL POLICY:** I hereby acknowledge that I have reviewed this practice's FINANCIAL POLICY as outlined on the opposite side of this form. I understand that if I have any questions regarding this policy that I may contact the billing department for clarification.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ INITIALS : \_\_\_\_\_ YR 1 \_\_\_\_\_ YR 2 \_\_\_\_\_ YR 3

## FINANCIAL POLICY

*This is an agreement between Wake Forest Pediatric Associates, PLLC, as creditor, and the Patient/Debtor named on this form.*

*In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Wake Forest Pediatric Associates, PLLC.*

*By executing this agreement, you are agreeing to pay for all services that are received.*

*Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.*

*Payment options: You choose to pay your copay, deductible or account balance by \_\_cash, \_\_check, or \_\_credit card on the day that treatment is rendered.*

*Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.*

*Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.*

*Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.*

*Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a collection agency or credit bureau.*

*Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.*

*Discounts: Patients not covered by insurance are eligible for a discount if they pay for their visit at the time of service. The current discount is 15%.*

*Returned checks: There is a fee (currently \$30) for any checks returned by the bank.*

*Missed appointment fee: All appointments that must be cancelled require 24-hour advance notification to this office. The second time a patient does not show up for an appointment, a \$20 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor. There will be a \$25 charge for missed physical & \$10 for missed flu shot appointments.*

*Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.*

*Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.*

*Transferring of Records: You will need to request in writing by completing paperwork in full to include parents name, address and phone number. You will also be asked to pay a reasonable copying fee as set by Healthport. Healthport is our medical record copying service.*

*Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.*

*Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.*

*Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force.*